Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
NORTHWEST TEXAS HOSPITAL
3255 W PIONEER PARKWAY
ARLINGTON TX 76013

Carrier's Austin Representative Box
15

Respondent Name
ACE AMERICAN INSURANCE CO

MFDR Date Received
NOVEMBER 28, 2007

MFDR Tracking Number
M4-08-2138-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated November 26, 2007: "We were asking the allowable to be 140%-over-Medicare. This would leave a supplement payment of due at this time based on through TWCC pursuant to Section 413-031 of the Labor Code. The patient was seen 06/12/07 and was billed in the amount of **$11990.50**. From then gave the claim time to process but only allowed **$2610.00**. Therefore, sent numerous letters for reconsideration to the carrier for additional reimbursement for this claim as for the total billed amount of **$11990.50**. The Claim was not paid at all not even 'fair and reasonable' like all other Texas counties in regarding Workers' Compensation."

Amount in Dispute: $11,990.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated November 14, 2007: "We are in receipt of the MDR request from DWC for Northwest Texas, dates of service 06/12/2007 through 06/15/2007, on the above mentioned claimant. Coventry/formally Concentra's Provider Bill Review department reviewed the above mentioned dates of service and found that the provider was not due additional money. It has been determined that Coventry will stand on our original recommendation of $2,610.00."

Response Submitted by: Coventry Worker's Comp Services for Ace American Insurance Co., P. O. Box 31143, Tampa, FL 33631-3143

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
June 12, 2007 Through June 15, 2007	Inpatient Hospital Services	$11,990.50	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.240, 31 *Texas Register* 3544, effective May 2, 2006, sets out the procedures for medical payments and denials.
2. 28 Texas Administrative Code §133.2, 31 *Texas Register* 3544, effective May 2, 2006, sets out the definition of final action.
3. 28 Texas Administrative Code §133.305 and §133.307, 31 *Texas Register* 10314, applicable to requests filed on or after January 15, 2007, sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.

The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of Benefits dated July 8, 2007

- 45 – Charges exceed your contracted/legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group odes PR or CO depending upon liability).
  (900-021) – ANY NETWORK REDUCTION IS IN ACCORDANCE WITH THE NETWORK REFERENCED ABOVE.
- W1 – Workers Compensation State Fee Schedule Adjustment
  (400-001) – THE INPATIENT REIMBURSEMENT HAS BEEN BASED ON PER DIEM, STOPLOSS FACTOR OR BILLED CHARGES WHICHEVER IS LESS.

Explanation of Benefits dated October 8, 2007

- 45 – Charges exceed your contracted/legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability).
  (900-021) – ANY NETWORK REDUCTION IS IN ACCORDANCE WITH THE NETWORK REFERENCED ABOVE.
- W1 – Workers Compensation State Fee Schedule Adjustment
  (400-001) – THE INPATIENT REIMBURSEMENT HAS BEEN BASED ON PER DIEM, STOPLOSS FACTOR OR BILLED CHARGES WHICHEVER IS LESS.

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. What are the requirements for reimbursement of the inpatient hospital services per 28 Texas Administrative Code §134.401?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason codes, "45 – Charges exceed your contracted/legislated fee arrangement. This change to be effective 6/1/07: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement and (900-021) – ANY NETWORK REDUCTION IS IN ACCORDANCE WITH THE NETWORK REFERENCED ABOVE." (Use Group Codes PR or CO depending upon liability)." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.401(c)(1) states "Reimbursement…Standard Per Diem Amount. The workers' compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows: Medical--$870; Surgical--$1,118; Intensive Care Unit (ICU)/Cardiac Care Unit (CCU) -- $1,560." 28 Texas Administrative Code §134.401(c)(2)(A) states "Reimbursement…Method. All inpatient services provided by an acute care hospital for medical and/or surgical admission will be reimbursed using a service related standard per diem amount…The complete treatment of an injured worker is categorized into two admission types; medical or surgical. A per diem amount shall be determined by the admission category." 28 Texas Administrative Code §134.401(c)(3)(A)(i and ii) states "Reimbursement Calculation…Explanation…Each admission is assigned an admission category indicating the primary service(s) rendered (medical or surgical). The applicable Workers' Compensation Standard Per Diem amount (SPDA) is multiplied by the length of stay (LOS) for admission."
3. Review of the submitted documentation finds that the services provided were medical; therefore the standard per diem amount of $870.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" The length of stay was three days. The medical per diem rate of $870 multiplied by the length of stay of three days results in an allowable amount of $2,610.00.

   28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than $250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement finds that the requestor billed 3 units of Morphine Sulf at $99.36/unit, for a total charge of $298.08. The requestor did not submit documentation to support what the cost to the hospital was for the Morphine Sulf. For that reason, reimbursement for these items cannot be recommended.

   The division concludes that the total allowable for this admission is $2,610.00 per diem. The respondent issued payment in the amount of $2,610.00. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. As a result, no additional reimbursement can be recommended.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 13, 2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.